IDAHO DEPARTMENT OF
# HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

January 11, 2008

Robert Collette
Aspen Hospice
3470 Washington Parkway Suite B
Idaho Falls, Idaho 83404

Provider #131541

Dear Mr. Collette:

On **December 21, 2007**, a Complaint Investigation was conducted at Aspen Home Health And Hospice. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00003238**

**Allegation #1**: Patients were placed on hospice that did not meet criteria.

Findings: An unannounced visit was made to investigate the complaint on 12/19 through 12/20/07. During the investigation staff were interviewed and 15 patient records were reviewed.

On 12/19/07 at 11:13 AM, the Owner/Director of the hospice agency stated staff used a "workbook" and "flipchart" to aid in the determination of patients' eligibility for Hospice services. He stated staff assessed patients at the start of care and recertification to ensure patients appropriateness for Hospice services. Additionally, he said all patients had to be approved for hospice services by 2 physicians.

On 12/19/07 at 11:13 AM, the Clinical Director confirmed that staff used the "Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases" 2nd edition, published by "The National Hospice and Palliative Care Organization" to assist them on the determination of patient eligibility for hospice services. She also confirmed that staff used a "flipchart", developed by the Hospice agency, to assess patients' eligibility for services.

On 12/19/07 at 11:44 AM, a Hospice nurse confirmed that she and the other Hospice's nurses used the "flipchart" and "workbook" to evaluate a patient's eligibility for services.

Of the 14 records reviewed all records contained the required signatures of two physicians, the patient's attending physician and the Hospice Medical Director. Additionally, all records reviewed contained documentation that the patients were appropriate for Hospice services.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

**Allegation #2**: Nurses were told by the owner to alter patients assessments to make the patient appear "sicker" then they were.

Findings: On 12/19/07 at 11:13 AM, the Owner/Director of the hospice agency stated he had not directed staff to falsify documentation in order to admit a patient to hospice services. He stated staff were provided with and educated on the use of a "workbook" and "flipchart" that aided them in the determination of the patients' eligibility for hospice services. Additionally, he said all patients had to be approved for hospice services by 2 physicians.

On 12/19/07 at 11:13 AM, the Clinical Director confirmed that staff used the "Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases" 2nd edition, published by "The National Hospice and Palliative Care Organization" to assist them on the determination of patient eligibility for hospice services. She stated staff had not been directed to make patients appear sicker than they were in order to admit or retain them on hospice services.

On 12/19/07 at 11:44 AM, a hospice nurse stated the Owner/Administrator had not directed her to change or falsify her documentation in order to admit or to retain a patient on services. She stated she was instructed to accurately describe the patient's condition. Additionally, she stated she had not been told to keep patients on services for a couple of certification periods to see how they were doing. She said if a patient's condition improved the patient was discharged from services and readmited at a later date.

On 12/19/07 at 1:11 PM another hospice nurse stated she had not been directed by the Owner/Administrator or supervisor to alter documentation, to make a patient appear sicker than they were, in order to admit or retain them on hospice services.

All 15 patient records reviewed contained the required signatures of two physicians, the patient's attending physician and the Hospice Medical Director.

Additionally, all records contained "Interdisciplinary Case Conference Report" forms that documented the Hospice's interdisciplinary team felt the patients remained appropriate for services.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

**Allegation #3**: The agency is not able to meet patient needs due to the shortage of staff to patient ratio.

Findings: On 12/19/07 at 12:29 PM, the Owner/Administrator stated they had sufficient nursing staff to provide services to their Hospice patients. He said Home Health staff were cross-trained in Hospice care to provide services to patients if they needed additional staffing. He said the additional staff enabled them to meet the needs of the patients.

On 12/19/07 at 12:38 PM, the Hospice Clinical Director stated there was not a shortage of nurses to see Hospice patients. She stated patients could be easily reassigned to another nurse to provide coverage for staff turn over or vacations if necessary. She said if there was an increase in the caseload of Hospice patients the Home Health Nurses, that had been trained in Hospice care, would assist.

On 12/19/07 at 1:11 PM, a Hospice nurse stated she had sufficient time to see her patients. She stated that as far as she knew the agency had sufficient staff to see all their Hospice patients. Additionally, she stated she was unaware of any time the agency was unable to meet patient needs due to a shortage of staff.

None of the 15 patient records contained documentation that patients' needs were unmet, or visits were missed due to a shortage of staff.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

**Allegation #4**: Patients have had many missed visits.

Findings: On 12/19/07 at 12:38 PM, the Hospice Clinical Director stated staff were to document on a "Missed Visits" form the reason for the missed visit. She stated some patients had more missed visits then others because they were unavailable at the time of the scheduled visit.

On 12/19/07 at 1:11 PM, a Hospice nurse stated if they missed a visit for any reason they were to document the day and reason on a "Missed Visits" form and fax the form to the patient's medical provider. She confirmed that some patients had more missed visits than others due to the patient's or family's request.

Five of the 15 patient records reviewed contained documentation of missed visits. All "Missed Visits" forms contained in the records documented the reason for the missed visit. The majority of the missed visit forms documented the reason for the missed visits were either at the patient's or family's request. Three missed visit forms documented the patient was not home when Hospice staff attempted home visits. Four of the 5 patients, whose records were reviewed, contained documentation they had 1 to 2 missed visits. One patient's record contained 5 missed visit forms. The forms documented that all the missed visits were at the patient's request. Additionally, all missed visit forms contained documentation that the information had been faxed to the patients' physicians.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

RAE JEAN MCPHILLIPS
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

RJM/mlw